

and the walls or outline of the collapsed sac could be easily traced through the abdominal parieties.

I have now another case under treatment, where no efforts have been made to exclude the air from entering the sac, and in which in two instances, half of the injected fluid could not be withdrawn; but no injurious effects were produced by its being retained in the system.

ART. X.—*Gunshot Wound of Chest and Abdomen.* By PHILIP S.
WALES, M. D., Surgeon U. S. N.

JACOB MYERS, ordinary seaman, aged 23, admitted March 7th, 1863, with a gunshot wound of the chest and abdomen. He was pale, with an anxious expression of countenance; the least movement caused excruciating pain across the epigastrium and loins. Dark blood issued from the posterior wound, which was between the transverse processes of the last dorsal and first lumbar vertebrae, immediately below the neck of the twelfth rib. Suffers from thirst, and the injection of the smallest amount of fluid causes vomiting and violent retching, the patient flexing strongly both thighs against his abdomen. During these efforts blood, almost black, sprints out at the lower opening, and bright arterial blood at the upper one, which was exactly over the right rib, an inch or two from its junction with the costal cartilage. The pulse was feeble, and the patient very restless, tossing about incessantly. With compressors and adhesive straps the bleeding was stopped. Soon after his admission he passed bloody urine, which coagulated in the chamber. Stimulants were had recourse to in exceeding small quantities at a time, under which treatment the pulse rose a little. Towards noon he became more restless, and complained that the adhesive straps oppressed his breathing; they were removed, but without affording the relief the patient vainly hoped would follow; the stomach was distended and made a perceptible projection in upper region of the abdomen. The eyes became glassy, the pulse vanished from the wrists and ankles, the respiration unequal and frequent, the inspiration was taken with a gasp, and the expiration became twice as long as the former, and seemed to be effected in two expulsive acts; the first sound of the heart was normal and strong, the second could not be heard at all. Later the pulsation of the larger arteries could not be felt; the first sound of the heart ceased, yet the patient gasped, and once raised his head from the pillow; with every gasp the corners of the mouth were depressed, the central portion of the

lower lip rose up and met its fellow. The head was strongly drawn to the left shoulder, and with one forcible expiration the patient expired.

The pectoral and abdominal muscles became first affected with *post-mortem* rigidity, then the muscles of the limbs, from which it gradually spread to the balance of the muscles of the head and trunk.

Autopsy eighteen hours after death.—The musket ball comminuted the eighth rib on left side, one or two inches from its attachment to the costal cartilage, passed through the diaphragm on the left side, three inches from its lower margin, making an aperture about $1\frac{1}{2}$ inches in diameter, wounding the upper part of the spleen, from which a copious hemorrhage had taken place into the pleural sac—the tissue of that organ being broken down into a black mass—then passed through the upper part of the left kidney, from which the blood had escaped to the extent of half a pint, but confined by the cellular capsule of that organ, the tissue of which was also broken down into a friable dark-coloured matter. The ball afterwards struck the upper and left extremity of the stomach, making a similar hole as in the diaphragm, and passed out of this viscus by an equally large opening about midway of its greater curve, and finally emerged below the diaphragm between the transverse processes of the twelfth dorsal and first lumbar, fracturing the neck of the left twelfth rib. About a quart of black blood was found in the left pleural cavity, and a mass of the omentum had been forced through the diaphragmatic opening and contracted adhesion to the external wound. A small quantity of dark coagula was found in the abdomen, and also around the opening in the stomach. The omentum was adherent on the left side of the abdomen, but not at the posterior orifice, being separated from it by coagula. The liver was healthy, and the gall-bladder distended with bile. The pericardium contained about two ounces of serum. The left lung was congested, and its lower margin hepatized, but not wounded; the posterior half of right lung congested also, the balance healthy. Some blood in the bladder, other organs healthy.

The diagnosis made in this case exactly accorded with the *post-mortem* lesions. The dark, or almost black blood, issuing from the wound on the posterior portion of left side, and its position, lead to the supposition of a wound of the spleen. The urine being bloody, pointed to the kidney as participating in the injury. Singular enough, notwithstanding the two large orifices in the stomach, not a drop of blood was vomited, though the patient expelled the contents of the stomach two or three times after his admission into the hospital, and from this fact it was surmised that the stomach might have escaped.

In this case the omentum did not project from the external wound, although adherent to the pleura costalis around it; yet I have witnessed such protrusion in several examples when the wound was much higher up, even at the sixth rib. A man presented this condition of things about three

months ago in this hospital. Surgeon Sharp informed me that he saw a case where the projecting omentum was taken for the lung tissue.

My patient survived the wound ten hours; and yet, in this short time, extensive adhesion had taken place between the serous layers of the peritoneum in the abdomen and this last membrane to the parietes of the chest.

All the cases of wounds of the spleen or kidney that have come under my notice have proved fatal in periods varying from ten hours to two days.

ART. XI.—*On the Use of Antimonii et Potassæ Tartras and Oleum Tiglii in establishing Adhesive Inflammation over Varieose Veins.*
By S. P. TURNER, M. D., one of the Physicians to the Howard Hospital and Infirmary for Incurables.

HAVING upon several different occasions been forced to resort to the obliteration of varicose veins of the lower extremities by means of issues established over their course, inducing a deposition of fibrin within the areolar tissue surrounding them, and not meeting the desired satisfaction from the use of potassa fusa or Vienna paste, because of the great tendency to considerable inflammation of the skin about the issue, and the impossibility of limiting the action to the exact location desired, and the usual very tedious process of cicatrization, I have finally resorted to a substitute, which appears to have answered the desired indication in the instances where it has been employed, without these objectionable results: it is the antimonii et potassæ tartras mixed with oleum tiglii to form a paste of the desired consistence.

From the following cases its mode of application can be seen, with a report of the state in which the patient was left when last under observation.

CASE 1. Robt. Mc_____, æt. 38, labourer. Some years since he received a severe blow upon the inner surface of the tibia, which was followed by enlargement of the neighbouring veins, gradually extending along the saphena three or four inches above the knee. Since that time he has suffered much each winter from ulceration at or near the internal malleolus, which usually disappeared after rest with the limb elevated, and the use of some stimulating application, until more recently the size of the veins had increased to such an extent as to render him almost unfit to follow his vocation, from the pain and sense of weight consequent upon the distension of the vessels at fault.

When he presented himself for treatment, there was a few inches above the internal malleolus a large irregular point of ulceration with elevated and indurated margins of a purplish colour from long-continued congestion. The internal saphena vein, beginning at the dorsum of the foot and extending to a point three inches above the internal condyle of the femur, was